Greenlake Psychiatric Services
Seattle, WA

Date

ADULT INTAKE INFORMATION

_____ _____ _____
Name Home Phone Business Phone

_____ _____
Cell phone/other phone Email

_____
Street Address City State Zip Code

_____ _____ Marital Status: Single □ Married □ Divorced □
Date of Birth Sex Widowed □ Living with partner □

_____ _____
Age Driver's License #

Referred by:_____

In Case of emergency, contact (Name, relationship and phone number):

PLEASE CIRCLE FORM OF PAYMENT: CASH INSURANCE

_____ _____ _____ _____
Primary Insurance Policyholder's Name Relationship Policyholder DOB

_____ _____ _____
Contract Number Group Number Policyholder's Employer

_____ _____ _____ _____
Secondary Insurance Policyholder's Name Relationship Policyholder DOB

_____ _____ _____
Contract Number Group Number Policyholder's Employer

****FOR STAFF USE ONLY****

_____ _____
Diagnosis Code

_____ _____
Psychiatrist Signature
Print Name:_____

Insurance	Deductible	Copay	Yearly maximum	Lifetime max
Primary				
Secondary				

If applicable:
Authorization #:_____Number of sessions:_____Dates covered:_____

Rev. 9/15

What are your reasons for seeking treatment at this time?

Have you seen a mental health or substance abuse professional (psychiatrist, psychologist, or social worker) in the past? If yes, explain.

Have you ever taken medications for a mental health, emotional problem, or substance abuse problem? If yes, explain.

Have you attended any self-help groups? If so, explain.

Family Information

Spouse's name Spouse's Date of Birth Spouse's Occupation

Children's Name(s), age(s), sex. Specify if child lives at home. Previous marriage(s) and children.

List significant extended family members. (Parent, brothers and sisters, etc.)

Explain any family history of physical illness or significant hospitalizations.

Explain any family history of mental or emotional illnesses, psychiatric hospitalization, history of suicide.

Any family history of substance abuse? Who was that? What substance(s) was abused?

Please describe any spiritual/religious/cultural affiliations.

Are social supports adequate at present? (Family, friends, co-workers)

Occupational/Educational History

Current employer and your job title

General satisfaction with your job

List past jobs and any comments:

Are you satisfied with your overall financial status? If not, explain.

Highest grade completed:

Describe your school performance:

Do you have any future plans for education? If yes, describe.

Leisure Activities

List some of your hobbies, activities, and talents.

With whom do you spend most of your free time?

Medical History

Name and address of your primary care physician

Height:_____ Weight:_____

When was your last physical exam?

Do you have any allergies? If yes, explain.

List all prescribed medications you are taking. Include dosage and frequency.

List all over-the-counter (including vitamins, minerals, diet pills, supplements, herbs, and other "natural" remedies) you are taking.

Have you ever had a problem with overuse of prescribed medications? If yes, explain.

Describe any surgeries, serious accidents, or hospital admissions.

Indicate whether you have had any of the following illnesses/symptoms.

	Now		Ever			Now		Ever	
	Yes	No	Yes	No		Yes	No	Yes	No
Anemia					High blood pressure				

Arthritis					Immune problems				
Asthma					Kidney disease				
Cancer					Paralysis				
	Now		Ever			Now		Ever	
	Yes	No	Yes	No		Yes	No	Yes	No
Diabetes					Prostate problems				
Earaches, infections					Seizures, epilepsy				
Emphysema					STDs				
Fainting/dizziness					Sleep problems				
Excessive fatigue					Stroke				
Headaches					Thyroid disease				
Head injury					Ulcers (GI)				
Heart problems					Urinary infections				
Hepatitis					Vision/hearing problems				
Other:					Other:				

Do you have physical pain? Yes_____No_____

If yes, rate the intensity of the pain: 1(mild) to 5 (severe): _____.

If yes, where is the pain located: _____.

If yes, how does it impact your functioning?

_____

Do you drink coffee, tea, cola, or consume other food, beverages, or medicines with caffeine? If so, please describe how much per day?

_____

Please provide information on your use of non-medical drugs.

Substance	**Used within 48 hrs.?**	**How often used?**	**Year first used?**	**When last used?**
Cigarettes/tobacco				
Alcohol				
Sleeping pills				
Marijuana				
Inhalants				
Cocaine/crack				
Heroin				
Other:				

Military History

Branch	Rank	Time in service	Active combat

Legal History

_____

Do you have any pending or prior legal problems? If yes, explain.

_____

Other:

Is there anything else you think we ought to know about you or you would like to tell us?

_____

Patient Signature:_____**Date:**_____

ADULT SYMPTOM CHECKLIST

NAME:_____ **AGE:**_____ **DATE:**_____

Please circle the symptoms that apply to you now in the past few weeks:

	Never	Rarely	Sometimes			Always
Depression	0	1	2	3	4	5
Crying spells	0	1	2	3	4	5
Hopelessness	0	1	2	3	4	5
Worthlessness	0	1	2	3	4	5
Sleep disturbance	0	1	2	3	4	5
Trouble falling asleep	0	1	2	3	4	5
Interrupted sleep	0	1	2	3	4	5
Early morning wakening	0	1	2	3	4	5
Oversleeping	0	1	2	3	4	5
Loss of appetite	0	1	2	3	4	5
Overeating	0	1	2	3	4	5
Weight loss or gain	0	1	2	3	4	5
If so, how much in the last 3-6 months: Gained:_____Lost:_____						
Lack of interest in usual things	0	1	2	3	4	5
Suicidal thoughts, present	Yes_____No_____					
Suicidal thoughts, past	Yes_____No_____					
Suicide attempt, gesture	Yes_____No____					
Homicidal thoughts	0	1	2	3	4	5
Anxiety, nervousness	0	1	2	3	4	5
Irritability, edginess	0	1	2	3	4	5
On the go, hard to relax	0	1	2	3	4	5
Mood swings	0	1	2	3	4	5
Racing thoughts	0	1	2	3	4	5
Hard to concentrate/ stay focused on task	0	1	2	3	4	5
Fatigue/tiredness	0	1	2	3	4	5
Bursts of energy	0	1	2	3	4	5
Worry	0	1	2	3	4	5
Fears of ordinary things (for example, crowds, germs, doctors, flying, closed spaces)	0	1	2	3	4	5
Yelling/screaming	0	1	2	3	4	5
On the go, hard to relax	0	1	2	3	4	5
Periodic overspending	0	1	2	3	4	5
Gambling problem	0	1	2	3	4	5
Alcohol problem (in the last year)	0	1	2	3	4	5
Drug problem (in the last year)	0	1	2	3	4	5
Blackouts, shakes tremors	0	1	2	3	4	5
Anxiety/panic attacks	0	1	2	3	4	5
Heart beating fast	0	1	2	3	4	5
Chest pains/tightness	0	1	2	3	4	5
Lightheadedness	0	1	2	3	4	5
Stomach upset	0	1	2	3	4	5
Sexual difficulties	0	1	2	3	4	5
Relationship problems	0	1	2	3	4	5
Work problems	0	1	2	3	4	5
Eating disorder	0	1	2	3	4	5
Suspiciousness/paranoia	0	1	2	3	4	5
Feeling controlled	0	1	2	3	4	5
Hitting/domestic violence	0	1	2	3	4	5
Hearing voices (that others don't)	0	1	2	3	4	5
Seeing things (that others don't)	0	1	2	3	4	5
Need for cleanliness	0	1	2	3	4	5
Need for organization	0	1	2	3	4	5
Counting behavior/thoughts	0	1	2	3	4	5
Rituals that you must do/ need to check and recheck	0	1	2	3	4	5
Unexplained physical symptoms	0	1	2	3	4	5
Trauma, other abuse	0	1	2	3	4	5

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